

FILED JAN 19 1949

STANDARD CERTIFICATE OF DEATH

State File No. 2467  
109

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| BIRTH NO.   |  | REG. DIST. NO. 318  |  | PRIMARY REG. DIST. NO. 1003   |  | Registrar's No.  |  |
| 1. PLACE OF DEATH<br>a. COUNTY St. Louis Mo.  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Mo. b. COUNTY |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN  |  | c. LENGTH OF STAY (In this place)   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN St. Louis                    |  | d. STREET ADDRESS (If rural, give location)<br>2822 a. North Florissant Ave.     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hosp.  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) Pauline  |  | a. (First)  |  | b. (Middle)   |  | c. (Last) Bischof  |  |
| 5. SEX Female   |  | 6. COLOR OR RACE White  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  |  | 8. DATE OF BIRTH July 12 1887  |  |
| 9. AGE (In years last birthday) 61  |  | 10. MONTHS 5  |  | 11. DAYS 20   |  | 12. IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY At home   |  | 11. BIRTHPLACE (State or foreign country) St. Louis Mo.                          |  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |   |  |   |  |  |  |
| 13a. FATHER'S NAME Unknown Kuehn  |  | 13b. MOTHER'S MAIDEN NAME Unknown   |  | 14. NAME OF HUSBAND OR WIFE Ben Bischof   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no  |  | 16. SOCIAL SECURITY NO. 190-01-0414   |  | 17. INFORMANT'S SIGNATURE OR NAME Ben Bischof   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Subdural Hemorrhage<br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Hypertension<br>DUE TO (c) Arteriosclerosis cerebral<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br>8/3 a 2 1/2 |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Few hours<br>years                           |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. |  |   |  |   |  |  |  |
| 23a. SIGNATURE H. B. Harrison (Degree or title)   |  |   |  | 23b. ADDRESS 607 No Grand   |  | 23c. DATE SIGNED 1-5-49  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 24b. DATE 1-7-49  |  | 24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery   |  | 24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.               |  |
| DATE REC'D BY LOCAL REG. JAN 5 1949   |  | REGISTRAR'S SIGNATURE J. B. Foster  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stroot Carroll 4600 Natl Bridge Ave.                                   |  |  |  |

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed

*Ben Hoffman*  
4366

Licensed Embalmer No. \_\_\_\_\_

P. O. Address *Hewes, MD*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**